

<i>SERFF Tracking Number:</i>	<i>BANN-125999750</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Banner Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41410</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L09I Individual Life - Flexible Premium</i>	<i>Sub-TOI:</i>	<i>L09I.001 Single Life</i>
	<i>Adjustable Life</i>		
<i>Product Name:</i>	<i>Amendment</i>		
<i>Project Name/Number:</i>	<i>Amendment to UL-08 AR/LU1281</i>		

Filing at a Glance

Company: Banner Life Insurance Company	SERFF Tr Num: BANN-125999750	State: ArkansasLH
Product Name: Amendment	SERFF Status: Closed	State Tr Num: 41410
TOI: L09I Individual Life - Flexible Premium		
Adjustable Life		
Sub-TOI: L09I.001 Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Ada Miller	Disposition Date: 02/03/2009
	Date Submitted: 01/29/2009	Disposition Status: Approved
Implementation Date Requested: 02/01/2009		Implementation Date:
State Filing Description:		

General Information

Project Name: Amendment to UL-08 AR	Status of Filing in Domicile: Authorized
Project Number: LU1281	Date Approved in Domicile: 01/29/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/03/2009	
State Status Changed: 02/03/2009	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	

The policy form, UL-08 AR, was approved by your department on August 27, 2008. We are amending this filing to remove references of the 2001 CSO Preferred Mortality Tables in the calculation of the standard non-forfeiture law.

We have attached an amended Actuarial Memorandum and the Endorsement form LU1281 with a requested implementation date of February 1, 2009.

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Life Application form LIA (10/08) & LU-1267 (10/08), previously approved by your department on October 17, 2008, will be used for this policy.

To the best of our knowledge, information and belief, this form complies with the rules and regulations of your department.

Company and Contact

Filing Contact Information

Nancy January, Vice President, Product Development	njanuary@lgamerica.com
1701 Research Boulevard	(301) 279-4868 [Phone]
Rockville, MD 20850	(301) 294-6964[FAX]

Filing Company Information

Banner Life Insurance Company	CoCode: 94250	State of Domicile: Maryland
1701 Research Boulevard	Group Code: 872	Company Type: Life Insurance
Rockville, MD 20850	Group Name:	State ID Number:
(301) 279-4809 ext. [Phone]	FEIN Number: 52-1236145	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$125.00
Retaliatory?	Yes
Fee Explanation:	1 form x \$125
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$125.00	01/29/2009	25354070

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	02/03/2009	02/03/2009

<i>SERFF Tracking Number:</i>	<i>BANN-125999750</i>	<i>State:</i>	<i>Arkansas</i>
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	<i>Adjustable Life</i>		
<i>Product Name:</i>	<i>Amendment</i>		
<i>Project Name/Number:</i>	<i>Amendment to UL-08 AR/LU1281</i>		

Disposition

Disposition Date: 02/03/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-125999750 State: Arkansas

Filing Company: Banner Life Insurance Company State Tracking Number: 41410

Company Tracking Number:

TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life

Product Name: Amendment

Project Name/Number: Amendment to UL-08 AR/LU1281

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	UL-08 AR		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Sample Policy Schedule Pages		Yes
Form	Endorsement		Yes

SERFF Tracking Number:	BANN-125999750	State:	Arkansas
Filing Company:	Banner Life Insurance Company	State Tracking Number:	41410
Company Tracking Number:			
TOI:	L09I Individual Life - Flexible Premium Adjustable Life	Sub-TOI:	L09I.001 Single Life
Product Name:	Amendment		
Project Name/Number:	Amendment to UL-08 AR/LU1281		

Form Schedule

Lead Form Number: LU1281

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LU1281	Policy/Cont	Endorsement ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			LU1281 Amendment for UL08.pdf



Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland
1-800-638-8428

ENDORSEMENT

This Amendment is to be added to and forms a part of the policy. Except as specifically altered by this Amendment, all of the provisions, conditions, limitations and exclusions of this policy remain in full force and effect.

The provisions of this policy entitled "**Cost of Insurance**" and "**Basis of Computations**" are amended as follows:

Cost of Insurance:

Delete the last sentence in the 2nd paragraph and replace it with:

"The guaranteed maximum rates are based on the 2001 Commissioners' Standard Ordinary Mortality Table, age nearest birthday."

Basis of Computations:

The first sentence is deleted and replaced with the following:

"Minimum cash surrender values are based on 3% interest per year, compounded yearly, and the 2001 Commissioners' Standard Ordinary Mortality Table, age nearest birthday."

IN WITNESS WHEREOF, the Banner Life Insurance Company has caused this Amendment to be signed by its President on the Policy Date.

A handwritten signature in black ink, reading "David S. Lenoburg". The signature is written in a cursive, flowing style.

President

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Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-125999750 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 41410
Company Tracking Number:
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life
Adjustable Life
Product Name: Amendment
Project Name/Number: Amendment to UL-08 AR/LU1281

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification 01/21/2009
Comments:
Readability certification is attached.
Attachment:
UL-08 with LU1281 Flesch Readability Certification.pdf

Review Status:

Satisfied -Name: Application 01/21/2009
Comments:
Application attached - previously approved by your department on October 17, 2008.
Attachments:
LIA (10-08).pdf
LU-1267 (10-08).pdf

Review Status:

Satisfied -Name: UL-08 AR 01/22/2009
Comments:
Policy form UL-08 AR is attached. The UL-08 AR was approved on August 27, 2008. This is the form that the amendment LU1281 will be attached to reflecting the removal of the word "Preferred" from 2 sentences in the policy.
Attachment:
UL08 AR.pdf

Review Status:

Satisfied -Name: Sample Policy Schedule Pages 01/29/2009
Comments:
Sample policy schedule pages attached
Attachment:
Amended Sample PSP for UL08.pdf

Readability Certification
UL-08 with LU1281

This is to certify that the forms in this filing have been tested and meets the minimum required Flesch reading ease score.

Flexible Premium Adjustable Life Insurance Form UL-08 with Amendment LU1281 has a score of 50.

The policy, except for specification pages, schedules, and tables is not less than 10-point type with one-point lead.

The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text of the policy or to any endorsements or riders.

A table of contents is included in the policy as it contains more than 3,000 words and consists of more than 3 pages.

*Nancy C. January, FSA, MAAA
Vice President, Product Development
Banner Life Insurance Company*

January 21, 2009
Date

Internet address: www.bannerlife.com**INSTRUCTIONS**

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

DO

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured, if required in your state.
- If you accept payment with the application:
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
 - Remit an amount equal to the first modal premium.
 - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
 - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
 - Send the TIAA with the application, give the Owner a copy.
 - All checks collected must be made payable to Banner Life Insurance Company.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 12. Please be sure to enter all agent information and your Banner agent number.

DO NOT

- Do not accept money on applications now applied for or pending with Banner Life Insurance Company totaling over \$1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.

Thank you for applying to Banner Life Insurance Company. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of Banner Life Insurance Company, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete, and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. Please be aware that if the application contains material misrepresentations or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer "yes" to the replacement question in the application; state law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and receive copies if you wish, of items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, MD 20850-3191.

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

NOTICE TO PROPOSED INSURED**(Please give to the Proposed Insured)****(continued)**

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Banner Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses) _____		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month _____ Day _____ Year _____	4. Social Security Number _____
5. a. Home Address Street _____ City, State _____ Zip _____				5. b. How Long _____
6. Phone Numbers Home () Work ()	7. State/Country of Birth _____	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____		
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	10. Driver's License Number and State of Issue or State ID Number _____			
11. Occupation (Include duties) _____		12. Annual Income _____		13. Total Net Worth _____
14. a. Employer's Name and Address and Nature of Business _____				14. b. How Long Employed _____
15. Have you ever used tobacco or nicotine products in any form? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No				
Product	Date last used (month/year)	Amount / Frequency		
Cigarettes				
Cigars				
Other				

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box ☐ and complete Section D.)

16. Primary				
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
17. Contingent				
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____

SECTION C OWNER

18. Owner is ☐ Proposed Insured ☐ Trust (also complete Section D) ☐ Other than Proposed Insured or Trust

Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).

Name _____ SSN or Tax ID # _____ Date of Birth _____

Address _____ City, State _____ Zip _____

Contact Phone # _____ Relationship to Proposed Insured _____

If Owner is a business, web site address _____ Email address _____

SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).

19. Exact Name of Trust _____	Trust Tax ID# _____
Current Trustee(s) _____	Date of Trust _____

PART 1 (continued)**SECTION E PAYOR**20. Send premium notices to: ☐ Insured ☐ Owner ☐ Other - If Other, complete the information below

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance \$ _____ 22. Plan of Insurance _____

23. Death Benefit Option (if available with Plan): ☐ Level Death Benefit ☐ Increasing Death Benefit24. Payment method: ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)25. Frequency of premium payment: ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (EFT only)

26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)

a. ☐ 1st Year Only \$ _____ 2nd Year and Thereafter \$ _____ b. ☐ Premium For All Years \$ _____27. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? ☐ Yes ☐ No

If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. (Provide details in Remarks section, Question 48.)

28. a. Date to Save Age? ☐ Yes ☐ No b. Specific Policy Date? ☐ Yes ☐ No Date _____**Additional Benefits (if available)**29. ☐ Waiver of Premium ☐ Other (description and amount) _____**SECTION G OTHER INSURANCE**30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. \$ _____

b. Of the above pending amount in 30.a., how much do you intend to accept? \$ _____

c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.)
If NONE state NONE.

Company	Policy Number	Face Amount	Business?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)

Yes No

☐ ☐

32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)

☐ ☐

33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)

☐ ☐

PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	<input type="checkbox"/>	<input type="checkbox"/>	
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	<input type="checkbox"/>	<input type="checkbox"/>	
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	<input type="checkbox"/>	<input type="checkbox"/>	
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	<input type="checkbox"/>	<input type="checkbox"/>	
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	<input type="checkbox"/>	<input type="checkbox"/>	
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION I OTHER ACTIVITIES		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION J PROPOSED INSURED FINANCIAL INFORMATION	
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:	
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)	_____
b. How was the need for the face amount determined? _____	_____
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	<input type="checkbox"/>
If Yes, type of bankruptcy and discharge date or charge off date. _____	<input type="checkbox"/>
46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms)	\$ _____
b. Gross annual unearned income (dividends, interest, rental income, etc.)	\$ _____
c. Is the Proposed Insured self-supporting?	<input type="checkbox"/>
If No, how much insurance is in-force on the life of the person providing the support?	\$ _____
What is that person's relationship to the Proposed Insured? _____	_____

PART 1 (continued)**SECTION K BUSINESS FINANCIAL INFORMATION**

Complete this section when applying for face amount over \$1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	\$	\$
b. Liabilities	\$	\$
c. Gross Sales	\$	\$
d. Net Income after Taxes	\$	\$
e. Fair Market Value of the business	\$	\$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)

Yes No

☐ ☐

i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?

☐ ☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:

I/we have read the application and all statements and answers contained in Part 1 and Part 2 of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to: (a) accept risk; (b) make or modify contracts; (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable; (d) waive any Company rights or requirements; (e) waive any information the Company requests; (f) discharge any contract of insurance; or (g) bind the Company by making promises respecting benefits upon any policy to be issued.

I agree that: **(1) I/we will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to and accepted by the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information for me. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, Maryland 20850-3191.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No

DECLARATION

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I/we understand that all premium checks are to be made payable to **Banner Life Insurance Company** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Please see fraud warnings on page 6 prior to signing this application.**

Signature of Proposed Insured Signed at _____ City/State on ____/____/____

Signature of Owner (if other than Proposed Insured) Signed at _____ City/State on ____/____/____
If Owner is a firm or corporation, include officers' title with signature

Print Owner/Officer Name and Title (if applicable)

Signature of Licensed Insurance Agent Signed at _____ City/State on ____/____/____

FRAUD WARNINGS

Arkansas, Kentucky, Louisiana, New Mexico, and Ohio

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information on an insurance application is guilty of a crime and may be subject to fines and imprisonment.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to a settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Nebraska, South Carolina, Texas

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

Washington, D.C., Maine, Virginia, Tennessee, and Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Maryland

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey

Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

1. Name of Proposed Insured _____ Date of Birth _____
2. Height _____ ft. _____ in. 3. Weight _____ lbs.
- If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No
☐ ☐

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section.
Include provider, date, symptoms, diagnosis and treatment.

Remarks - Explain All Yes Answers
Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? ☐ ☐
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? ☐ ☐
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? ☐ ☐

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Attended or joined any organization due to alcohol or related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the past 2 years ?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, list in Remarks section at right.			
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, give details. _____			
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

Signature of Proposed Insured

Signed at _____ on ____/____/____
City/State Date

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured_____
Date of this TIAA_____
Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent_____
Licensed Insurance Agent Number

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured_____
Date of this TIAA_____
Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent_____
Licensed Insurance Agent Number

AGENT'S REPORT

1. Name of Proposed Insured _____ Date of Birth _____
2. Number of years you have known the primary Proposed Insured _____
3. Who first suggested the purchase of this insurance? ☐ Agent ☐ Owner/Applicant ☐ Proposed Insured ☐ Other _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. Was the application signed after all questions were answered? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you personally see the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? ...
If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Premium Class Quoted _____ | | |
| 10. Are there any personal or business companion applications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please provide name and date of birth in the Remarks section below. | | |
| 11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. | | |

Remarks**STATEMENTS BY AGENT****I certify that:**

- I asked and carefully explained each question to the Proposed Insured and Owner/applicant before recording each answer prior to the application being signed;
- The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The Proposed Insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
- I have given the Notice to Proposed Insured attached to this application to the Proposed Insured;
- If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
- I have explained to the Proposed Insured that if money is submitted with this application, conditions of the Temporary Insurance Application and Agreement must be met.
- If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the Company to do so.

Signature of Licensed Insurance Agent _____	Date _____	Phone No. () _____
Print Name of Above Signature _____		Agent # _____ SSN _____
Print Name of Agency, if different from above _____		Share of commission _____
Signature of Additional Licensed Insurance Agent _____	Date _____	Phone No. () _____
Print Name for Above Additional Signature _____		Agent # _____ SSN _____
Print Name of Additional Agency, if different from above _____		Share of commission _____

GENERAL AGENT INFORMATION

GA name _____ GA # _____ Case Manager _____

1. Name of Proposed Insured _____ Date of Birth _____
2. Height _____ ft. _____ in. 3. Weight _____ lbs.
- If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. ☐ Yes ☐ No

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

Remarks - Explain All Yes Answers
Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? ☐ Yes ☐ No
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? ☐ Yes ☐ No

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Attended or joined any organization due to alcohol or related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the past 2 years ?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, list in Remarks section at right.			
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, give details. _____			
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

Signature of Proposed Insured

Signed at _____ on ____/____/____
City/State Date

Name of Proposed Insured _____ Date of Birth _____

Instructions to the Examiner -

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

<p>1. Height (in shoes) _____ ft. _____ in. Weight (clothed) _____ lbs.</p> <p>a. Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/> b. Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, please explain _____ _____</p> <p>2. Measurements (males only) Chest (full inspiration) _____ in. Chest (forced expiration) _____ in. Abdomen (at umbilicus) _____ in.</p>	<p>3. Blood Pressure (record 3 readings)</p> <table border="1" style="width: 100%;"> <tr> <td>Systolic</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Diastolic</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <p>4. Pulse At rest _____ Describe any irregularities (number per minute, etc.) _____ _____</p> <p>5. Are blood and urine specimens being collected and mailed to the lab? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Systolic	_____	_____	_____	Diastolic	_____	_____	_____
Systolic	_____	_____	_____						
Diastolic	_____	_____	_____						

IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 6 AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Stomach, abdominal organs?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Is the liver enlarged or tender?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (including spine, joints, amputations and deformities)?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.)	<input type="checkbox"/>	<input type="checkbox"/>	

Name of Proposed Insured _____

PART 3 - Medical Examiner's Report (continued)

7. To be completed if number 6.i. is answered Yes or if requested:				
	Yes	No	Remarks	
a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	<input type="checkbox"/>	<input type="checkbox"/>		
b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?	<input type="checkbox"/>	<input type="checkbox"/>		
c. Are there gallops (S3 or S4)?	<input type="checkbox"/>	<input type="checkbox"/>		
d. Is/are there ejection sound(s) or systolic click(s)?	<input type="checkbox"/>	<input type="checkbox"/>		
e. Is/are there murmur(s) present? If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	<input type="checkbox"/>	<input type="checkbox"/>		
8. a. Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?		<input type="checkbox"/>	<input type="checkbox"/>	
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age?		<input type="checkbox"/>	<input type="checkbox"/>	
9. a. Were you acquainted with the Proposed Insured prior to this examination?		<input type="checkbox"/>	<input type="checkbox"/>	
b. Are you the Proposed Insured's personal physician?		<input type="checkbox"/>	<input type="checkbox"/>	
c. Was the examination conducted in a language other than English? If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.		<input type="checkbox"/>	<input type="checkbox"/>	
d. Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured?		<input type="checkbox"/>	<input type="checkbox"/>	
10. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other _____				
Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.				

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.

Name of Proposed Insured

Examined at _____,
Street address, City and State

this _____ day of _____, 20____ at _____ AM/PM.

Print Examiner's name _____ Signature of Examiner _____
☐ Paramed ☐ MD ☐ D.O.

Paramed Company _____ Telephone number _____

Address _____



**1701 Research Boulevard
Rockville, MD 20850
800-638-8428**

Please Read This Notice Carefully - This policy is a legal contract between the policy owner and Banner Life Insurance Company. Within 20 days after this policy is received, it may be returned to the agent through whom it was purchased or to our home office. We will then refund any premium paid and the policy will be deemed void from the beginning.

In this policy, Banner Life Insurance Company will be referred to as "we", "our" or "us". The insured will be referred to as "you", "your" or "yours".

If we receive due proof that you died while this policy was in force and before the maturity date, we will pay to the beneficiary the proceeds of this policy. This death benefit is described in the insurance coverage provisions.

We will pay to the owner any cash surrender value on the maturity date if you are then living and this policy is in force.

Payment of these benefits and continuation of coverage prior to the maturity date are subject to the provisions of this policy; payment of premiums in addition to scheduled premiums may be required to maintain this coverage as described in the grace period provision of this policy.

This policy is issued in consideration of the application and of the payment of the first premium as provided herein. A copy of the application is attached and is made a part of the policy.

If you require further assistance, the Maryland Insurance Administration's toll-free number is 800-492-6116.

Signed for Banner Life Insurance Company at our home office in Rockville, Maryland, on the policy date.

A handwritten signature in cursive script, reading "Bryan R. Newcombe".

Secretary

A handwritten signature in cursive script, reading "David I. Lenaburg".

President

Flexible Premium Adjustable Life Insurance

**Adjustable death benefit is payable upon
your death prior to the maturity date**

**Flexible premiums are payable during your
lifetime until the maturity date**

Cash surrender value, if any, payable at maturity

**Plan, benefits, classification and period
for which premiums are payable as stated
in the policy schedule**

**This policy is non-participating and no
dividends are payable**

TABLE OF CONTENTS

Amount of Proceeds.....	10
Annuity Payment Option Tables.....	13
Beneficiary Provisions.....	10
Definitions.....	4
Election of Payment Options.....	11
General Provisions.....	9
Guaranteed Values.....	6
Insurance Coverage Provisions.....	10
Nonforfeiture Provisions.....	7
Ownership.....	4
Payment of Proceeds.....	11
Payment Options.....	11
Policy Loans.....	8
Premiums.....	4
Table of Guaranteed Minimum Death Benefit Factors.....	15

Concluded With:

Riders, benefits, amendments, and endorsements, if any; and copy of applications

PLEASE READ YOUR POLICY CAREFULLY

POLICY SCHEDULE

Policy Number: 010000000

Insured:	JOHN DOE	Planned Annual Premium:	\$1,000.00
Issue Age/Sex	35 Male	Issue Date:	MAR 1, 2008
Owner:	JOHN DOE	Policy Date:	MAR 1, 2008
Premiums Payable	TO AGE 120	Maturity Date:	MAR 1, 2093

SCHEDULE OF BENEFITS

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>AMOUNT</u>	<u>ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
UL-08 AR	FLEXIBLE PREMIUM ADJUSTABLE LIFE	\$100,000.00	\$1,000.00	STANDARD NON-TOBACCO

Note:

Due to the flexible nature of this Flexible Premium Adjustable Life policy, it is possible that coverage will terminate before the maturity date. This can occur if no premiums are paid after payment of the initial premium or if subsequent premiums are too infrequent or insufficient to provide continued coverage to the maturity date.

Policy Schedule (Continued)

Policy Number: 010000000

INSURANCE COVERAGE INFORMATION:

Initial Specified Amount:	\$ 100,000.00
Current Specified Amount:	\$ 100,000.00
Minimum Specified Amount:	\$ 100,000.00

PREMIUM LIMITATION INFORMATION:

Guideline Level Premium:	\$1,125.00
Guideline Single Premium:	\$13,912.00

GRACE PERIOD PROVISION INFORMATION:

Monthly Lifetime Guarantee Premium:	\$ 46.83
Monthly Minimum Guarantee Premium:	\$ 26.83
Designated No-Lapse Interest Rate:	5% annually

See page 5 for an explanation of the use of the no-lapse interest rate.

EXPENSE CHARGES:

Monthly Policy Fee:	\$ 5.00
Premium Expense Charge:	7%
Monthly Administrative Charge:	\$ 26.50

RATES:

Minimum Guaranteed Interest Rate	3%
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Policy Schedule (Continued)

Policy Number: 010000000

Table of Full Surrender Charges

POLICY YEAR	SURRENDER CHARGE
1	\$ 1922.00
2	\$ 1785.00
3	\$ 1647.00
4	\$ 1510.00
5	\$ 1373.00
6	\$ 1236.00
7	\$ 1098.00
8	\$ 961.00
9	\$ 824.00
10	\$ 686.00
11	\$ 549.00
12	\$ 412.00
13	\$ 275.00
14	\$ 137.00
15	\$ 0.00
	AND THEREAFTER

Policy Schedule (Continued)

Policy Number: 010000000

GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES PER \$1,000
RATING CLASSIFICATION: MALE STANDARD NON-TOBACCO

POLICY YEAR	ATTAINED AGE	MAXIMUM RATE	POLICY YEAR	ATTAINED AGE	MAXIMUM RATE
1	35	0.104167	44	78	4.955000
2	36	0.109167	45	79	5.512500
3	37	0.114167	46	80	6.117500
4	38	0.121667	47	81	6.802500
5	39	0.130833	48	82	7.510000
6	40	0.139167	49	83	8.265833
7	41	0.150833	50	84	9.100000
8	42	0.165000	51	85	10.025833
9	43	0.180833	52	86	11.049167
10	44	0.200000	53	87	12.156667
11	45	0.222500	54	88	13.335000
12	46	0.243333	55	89	14.568333
13	47	0.266667	56	90	15.844167
14	48	0.279167	57	91	17.025000
15	49	0.295833	58	92	18.245833
16	50	0.315833	59	93	19.523333
17	51	0.340833	60	94	20.865833
18	52	0.374167	61	95	22.265833
19	53	0.410000	62	96	23.649167
20	54	0.457500	63	97	25.124167
21	55	0.513333	64	98	26.698333
22	56	0.570833	65	99	28.378333
23	57	0.633333	66	100	30.175000
24	58	0.685000	67	101	31.600833
25	59	0.745000	68	102	33.120000
26	60	0.820833	69	103	34.736667
27	61	0.912500	70	104	36.456667
28	62	1.025833	71	105	38.260833
29	63	1.152500	72	106	40.179167
30	64	1.285833	73	107	42.218333
31	65	1.425833	74	108	44.385833
32	66	1.568333	75	109	46.688333
33	67	1.712500	76	110	49.132500
34	68	1.868333	77	111	51.728333
35	69	2.027500	78	112	54.483333
36	70	2.222500	79	113	57.409167
37	71	2.440000	80	114	60.512500
38	72	2.727500	81	115	63.805833
39	73	3.029167	82	116	67.299167
40	74	3.347500	83	117	71.004167
41	75	3.694167	84	118	74.935000
42	76	4.053333	85	119	79.101667
43	77	4.470000			

DEFINITIONS

Home Office and Administrative Office

Our home office and administrative office is located at 1701 Research Boulevard, Rockville, Maryland 20850.

Policy Date, Month, Year, and Anniversary

The policy date is stated in the policy schedule. Each policy month begins on the same day of each month as the policy date. The first day of each policy month is a monthly anniversary. Each policy year begins on the same day and month as the policy date. A policy anniversary occurs on the first day of each policy year after the first policy year.

Issue Date

The issue date is the date we complete the processing of your approved application, and issue this life insurance policy to you or the owner.

Attained Age

Attained age means your age on the birthday nearest to the last policy anniversary.

Written Notice/Recording Thereof

Written notice means a notification or request received from the owner in a form satisfactory to us. Written notices are recorded at our administrative office. We will not be responsible for the validity of any written notice.

Riders and Benefits

Riders and benefits are attachments to the policy which provide additional coverages and benefits.

Maturity Date

The maturity date is shown in the policy schedule.

On the maturity date, this policy will be terminated and you will receive any remaining cash surrender value.

It is possible that the policy will terminate prior to the maturity date if:

1. the total premiums paid are not sufficient to continue coverage to the maturity date as described in the insufficient cash surrender value provision; and/or
2. a policy loan or partial surrender is made.

Extended Maturity Date

The policy owner can elect to extend the maturity date beyond age 120. This new maturity date is defined to be the extended maturity date. The death benefit will be continued as the amount in effect at age 120 and there will be no further monthly deductions from the account value.

The policy may not qualify as life insurance under federal tax law after the insured reaches age 120 and may be subject to adverse tax consequences. A tax advisor should be consulted before the owner chooses to continue the policy after age 120.

Partial withdrawals can continue to be made after age 120. New policy loans and loan repayments shall be permitted. Interest will continue to accrue on and be added to any outstanding loan balance.

OWNERSHIP

Unless otherwise noted, the owner of this policy is shown in the policy schedule. During your lifetime, only the owner may exercise all the rights and agree with us as to changes in the policy. Changes shall take effect on the date written notice was signed unless otherwise specified by the owner. If you are not the owner and the owner dies, then you will become the owner unless a contingent owner has been named.

Control of Policy

During your lifetime and subject to the terms of any beneficiary designation or assignment, the owner may:

1. assign or surrender this policy;
2. obtain a policy loan;
3. obtain a partial surrender;
4. make a change in this policy with our consent;
5. transfer the ownership of this policy; and
6. exercise other rights and receive other benefits as defined in this policy.

Assignment of Policy

This policy may be assigned. We will not be responsible for the validity of an assignment. We will not be liable for any payments made or actions taken before written notice of any assignment is received by us. Changes shall take effect on the date written notice was signed unless otherwise specified by the owner. Payments to any assignee will only be made in a lump sum.

PREMIUMS

Payment of Premiums

The first premium must be paid before any insurance becomes effective. The due date of the first premium is the policy date. Premiums are payable in advance to us. Premiums after the first premium are payable at our administrative office. A premium receipt signed by one of our officers will be furnished upon request. In no event may premiums be paid beyond the maturity date.

Planned Premiums

The amount of any planned premium may be increased or decreased subject to the Premium Limitation provision.

Notices for planned premiums will be sent to the owner. The owner may change the frequency of premium notices to any frequency we offer on the date such change is requested.

Unscheduled Premiums

Additional premium payments may be made at any time prior to the maturity date. Unscheduled premium payments are subject to the premium limitation provision.

Premium Limitation

The Internal Revenue Service has established certain guidelines which determine the qualification of this policy as a life insurance policy. These guidelines establish that the sum of the premiums paid under this policy may not at any time exceed the premium limitation as of such time. The premium limitation is the greater of (1) or (2) where:

- (1) is the guideline single premium; and
- (2) is the sum of the guideline level premiums for the number of years this policy has been in force.

The guideline single premium and the guideline level premium are shown in the policy schedule. These guideline premiums will be adjusted if:

1. the specified amount is changed; or
2. there is a change to any riders or benefits attached to this policy which the Internal Revenue Service has defined as qualified benefits.

The premium limitation will not apply if a premium payment is required under the grace period provision to prevent termination of this policy.

Qualification as Life Insurance

If at any time, the premiums paid under this policy exceed the amount allowable for tax qualification as life insurance, or the amounts required to avoid modified endowment contract status, the owner may elect to have the excess amount refunded with interest from such date. Any appropriate adjustments to the account value and death benefit shall also be made on the date of such refunds as described above.

In no event shall the death benefit under the policy ever be less than the amount necessary to ensure or maintain its qualification as a life insurance policy for federal tax purposes or its qualification for the federal income tax exclusion. To the extent that the death benefit is increased by these provisions, appropriate adjustments will be made to the monthly deductions that are consistent with such increases.

Net Premium

A net premium is a percentage of the premium paid. This percentage is equal to 100% minus the premium expense charge shown in the policy schedule.

Monthly Minimum Guarantee Premium

The monthly minimum guarantee premium is shown in the policy schedule. This premium will change whenever:

1. the specified amount of this policy is increased or decreased;
2. the rating classification is changed;
3. there is an increase in the amount of insurance of any riders or benefits attached to this policy; or
4. riders or benefits are added to or deleted from this policy.

We will send to the owner a policy schedule showing the revised premium.

Monthly Lifetime Guarantee Premium

The monthly lifetime guarantee premium is shown in the policy schedule. This premium will change whenever:

1. the specified amount of this policy is increased or decreased;
2. the rating classification is changed;
3. there is an increase in the amount of insurance of any riders or benefits attached to this policy; or
4. riders or benefits are added to or deleted from this policy.

We will send to the owner a policy schedule showing the revised premium.

Grace Period

This policy provides for a grace period of 61 days to pay sufficient premiums to prevent policy termination. Except as provided in the no-lapse provision described below, this policy will enter the grace period if the cash surrender value is less than the monthly deduction. We will send notice of the premium due to the owner's last known address and to any assignee of record at least 30 days prior to the date the policy is to terminate. If the premium due on such monthly anniversary is not paid within the grace period, all coverage under this policy will terminate without value at the end of the grace period. If a death claim occurs during the grace period, overdue monthly deductions will be deducted from the proceeds.

No-Lapse Provision

There are two no-lapse provisions with this policy. During the first 10 policy years, this policy will not enter the grace period if the Minimum Premium Requirement has been met. The Minimum Premium Requirement is

met if the sum of the premiums less any partial surrenders equals or exceeds the cumulative sum of the minimum monthly guarantee premiums.

The second no-lapse provision is the lifetime no-lapse provision. For all policy years, this policy will not enter the grace period if the Lifetime Premium Requirement has been met. The Lifetime Premium Requirement is met if (a) equals or exceeds (b) where:

- (a) is the total accumulated premiums, equal to (1) + (2) - (3) + (4) where
- (1) previous month's total accumulated premiums
 - (2) total premiums paid during the month
 - (3) partial surrenders made during the month
 - (4) one month's interest on (1) + (2) - (3), using the designated no-lapse interest rate shown in the policy schedule.

On the policy date (a) is equal to 0.

- (b) is the total accumulated lifetime monthly guarantee premiums, equal to (1) + (2) + (3) where
- (1) previous month's total accumulated lifetime monthly guarantee premiums
 - (2) lifetime monthly guarantee premium for the policy month
 - (3) one month's interest on (1) + (2), using the designated no-lapse interest rate shown in the policy schedule.

On the policy date (b) is equal to 0.

This requirement is tested on each monthly anniversary.

Additionally, for both the minimum premium and lifetime no-lapse provision, the policy will lapse if the indebtedness equals or exceeds (1) minus (2) minus (3) where

- (1) account value
- (2) is the surrender charge; and
- (3) is the monthly deduction for the following month.

Reinstatement

A policy which terminates in accordance with the grace period provision may be reinstated within five years after the expiration of the grace period if:

- 1. the owner submits a written application;
- 2. evidence of your insurability is received and approved by us; and
- 3. a premium sufficient to keep this policy in force for three months is paid.

The account value on the effective date of reinstatement will be the account value on the date of entering the grace period plus the net premiums paid at reinstatement.

If this policy is reinstated, the surrender charges will be the same as if this policy had been continuously in force from the policy date.

The effective date of reinstatement will be the monthly anniversary on or next following the date we approve the application for reinstatement.

GUARANTEED VALUES

Account Value

On each monthly anniversary, the account value will equal (1) plus (2) plus (3) minus (4) minus (5) where:

- (1) is the account value on the preceding monthly anniversary;
- (2) is one month's interest on item (1);
- (3) is any net premium received since the preceding monthly anniversary, plus interest from the day such premium is received at our administrative office until the end of the policy month in which such premium was received;
- (4) is the monthly deduction described below for the policy month following the monthly anniversary; and
- (5) is any partial surrender, plus any partial surrender charge, made since the preceding monthly anniversary, plus interest from the day such surrender is made until the end of the policy month in which such surrender is made.

On any day other than a monthly anniversary, the account value will be calculated on a basis consistent with that prescribed above.

The account value on the policy date will be the first net premium less the monthly deduction for the month following the policy date.

Monthly Deduction

The monthly deduction for a policy month will equal (1) plus (2) plus (3) plus (4) where:

- (1) is the cost of insurance described below;
- (2) is the cost for the policy month of additional coverage provided by riders and benefits;
- (3) is the monthly policy fee shown in the policy schedule; and
- (4) is the monthly administrative charge described below.

Interest Rate

The guaranteed interest rate used in the calculation of the account value is listed on the specifications page. Interest in excess of the guaranteed rate may be used in the calculation of the account value at such increased rate and in such manner as determined by us. The interest rate applied to account value equal to outstanding policy loans may be different from the rate applied to the remaining account value. However, such rate will never be less than the guaranteed interest rate.

Monthly Administrative Charge

The monthly administrative charge is shown in the policy schedule. Upon any increase or decrease in specified amount, the monthly administrative charge will be revised proportionately.

Cost of Insurance

The cost of insurance is determined on a monthly basis. The cost is (1) multiplied by the result of (2) minus (3) where:

- (1) is the monthly cost of insurance rate described below;
- (2) is the death benefit at the beginning of the policy month, divided by 1 plus the monthly equivalent of the guaranteed interest rate; and
- (3) is the account value at the beginning of the policy month, prior to the deduction of item (1) of the monthly deduction provision for the following month.

If there has been an increase in specified amount, then the account value will be allocated proportionately among the original specified amount and each increase in specified amount.

Cost of Insurance Rate

The monthly cost of insurance rate is based on your attained age, sex, and rating classification. The rating classification is shown in the policy schedule.

The cost of insurance rates are based on our expectations as to future experience. However, the cost of insurance rates for your rating classification will not be greater than the guaranteed maximum rates shown in the policy schedule. The guaranteed maximum rates are based on the 2001 Commissioners' Standard Ordinary Preferred Mortality Table, age nearest birthday.

If there is an increase in specified amount, the rating classification for such increase will be shown in the policy schedule. If the rating classification for the

increase is different from previous rating classifications, additional policy schedule pages will be issued with the applicable guaranteed maximum cost of insurance rates for that rating classification.

We may use lower, non-guaranteed monthly cost of insurance rates than those shown in the policy schedule at our sole option and discretion. Any change in the cost of insurance rates will apply to all persons of the same class. Such changes are determined and redetermined prospectively. We will not recoup any prior losses nor distribute past gains by means of such changes in cost of insurance rates.

Basis of Computations

Minimum cash surrender values are based on 3% interest per year, compounded yearly, and the 2001 Commissioners' Standard Ordinary Preferred Mortality Table, age nearest birthday. A detailed statement of the method of computation of cash surrender values under this policy has been filed with the state in which this policy is delivered. Cash surrender values under this policy are never less than the minimum values required by the state in which this policy is delivered.

NONFORFEITURE PROVISIONS**Continuation of Insurance**

This policy will remain in effect until premiums paid plus credited interest are insufficient to continue coverage. The policy will then terminate as described in the grace period provision.

Surrender

The owner may surrender this policy and receive the cash surrender value during your lifetime. Surrender terminates this insurance. Surrender will be effective on the next monthly anniversary of this policy. We may postpone payment for as long as six months from the effective date of surrender. We reserve the right to require the return of the policy.

Cash Surrender Value

The cash surrender value will be (1) minus (2) minus (3) where:

- (1) is the account value on the date of surrender;
- (2) is any policy indebtedness; and
- (3) is the surrender charge described below.

If surrender is requested within 30 days after a policy anniversary, the cash surrender value will not be less than the cash surrender value on such anniversary, less any policy loans or partial surrenders made on or after such anniversary.

The surrender will be paid in cash or under an annuity payment option.

Surrender Charge

The surrender charge applicable for the initial specified amount is shown in the policy schedule.

An additional surrender charge may be applicable after any increases in specified amount. If applicable, the additional surrender charge will be added to any remaining surrender charge to determine the total surrender charge. We will send you a new policy schedule showing the total surrender charge for applicable policy years after an increase in specified amount.

Partial Surrender

A partial surrender of this policy may be made during your lifetime and prior to the maturity date. The owner must send us a written request for a partial surrender. The amount paid may not exceed the cash surrender value on the date of partial surrender less \$275. We reserve the right to limit the number of partial surrenders to six within a policy year.

When a partial surrender is made, the account value will be reduced by the amount of the partial surrender. The specified amount will be reduced by the same amount. The specified amount remaining in force after a partial surrender will be subject to the limits and minimum amount described in the decrease in specified amount provision.

We may postpone payment of a partial surrender for as long as six months from the effective date of the partial surrender. However, a partial surrender used to pay a premium on any policy issued by us will not be postponed.

Partial Surrender Charge

Upon a partial surrender of the policy, the account value and the specified amount will be reduced by a partial surrender charge. The amount of the partial surrender charge will be equal to (1) plus (2), where:

- (1) is an administrative charge, which will never exceed \$25; and
- (2) is the full surrender charge multiplied by the ratio of the partial surrender amount to the account value of the policy.

Future surrender charges will be reduced by the ratio described in (2) above.

POLICY LOANS

While this policy is in force, the owner may obtain all or part of the available loan value by written notice. This policy, assigned to us, is the only security needed. We may postpone making a loan for as long as six months from the date the notice is received at our administrative office. However, a policy loan used to pay a premium on any policy issued by us will not be postponed.

Loan Value

The loan value will be (1) minus (2) where:

- (1) is the account value of this policy; and
- (2) is the surrender charge as described in the nonforfeiture provisions.

Available Loan Value

The available loan value will be the loan value less the sum of:

1. any existing policy loan;
2. loan interest in advance to the next policy anniversary; and
3. any due and unpaid monthly deductions payable prior to the date of the next planned premium payment, based upon the frequency of premium notices that are sent to the owner. Monthly deductions for future policy months will be based upon guaranteed cost of insurance rates and guaranteed monthly policy fees. No more than three monthly deductions may be deducted from the loan value.

Interest on Policy Loans

Interest on policy loans will be payable in advance from the date of the loan to the next policy anniversary at the annual interest rate of 5%. Interest is payable in advance at the beginning of each policy year. If interest is not paid when due, it will be added to the policy loan and bear interest at the same rate.

Repayment of Policy Loans

A policy loan may be repaid in full or in part at a minimum rate of \$50.00 at any time while this policy is in force. Failure to pay back the policy loan will not terminate this policy unless the policy indebtedness equals or exceeds (1) minus (2) minus (3), where:

- (1) is the account value;
- (2) is the surrender charge; and
- (3) is the monthly deduction for the following month.

If this happens, the policy will terminate. The policy will not lapse until at least 30 days' notice has been mailed to the last known address of the insured or policy owner and any assignee of record.

GENERAL PROVISIONS

Contract

This policy, attached riders, amendments, benefits, reinstatement applications, and the application, as well as any supplemental applications for additional amounts, form the entire contract. Only the President, a Vice President, or the Secretary of Banner Life Insurance Company may change or waive any provision in this contract. Any changes or waivers must be in writing.

We may not change or amend this policy without the owner's consent except as expressly provided in the policy. However, we may change or amend this policy if such change or amendment is necessary for it to comply with any state or federal law, rule or regulation.

Statements

Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this policy or in defense of a claim only if:

1. they are contained in the application, supplemental application, or in an endorsement or amendment; and
2. a copy of that application, endorsement or amendment is attached to the policy at issue or is made a part of the policy when a change becomes effective.

Not Contestable After Two Years

We cannot contest this policy after it has been in force two years during your lifetime from the date of issue or the date of any reinstatement, except for nonpayment of premium. If the policy has been reinstated after the policy is in force for two years after the date of issue, only statements in the reinstatement application may be contested. If reinstatement occurs within two years of the issue date we may:

1. contest statements on the original application for two years after the date of issue; and
2. contest statements on the reinstatement application for two years after the date of reinstatement.

Any increase in specified amount, which requires evidence of insurability, will be incontestable only after such increase has been in force during your lifetime for two years following the effective date of such increase.

Misstatement of Age and Sex

If your age or sex has been misstated, we will change the specified amount to that which would have been purchased at the correct age and sex by the most recent monthly deduction. The date of adjustment will be the date the misstatement was discovered if you are living on that date; otherwise, it will be the date of death.

If you are living on the date of adjustment, we will use the adjusted specified amount, the correct monthly cost of insurance rates, and the correct administrative charges in making future calculations of the account value, the cash surrender value, and the death benefit.

Non-participating

This policy is non-participating and the owner will not share in the company's profits or surplus. We will pay no dividends on this policy.

Effective Date of Coverage

The effective date of coverage under this policy will be as follows:

1. for all coverage provided in the original application, the effective date will be the policy date;
2. for any increase or addition to coverage, the effective date will be the monthly anniversary on or next following the date the supplemental application is approved by us; and
3. for any insurance that has been reinstated, the effective date will be the monthly anniversary on or next following the date the application for reinstatement is approved by us.

Termination

All coverage under this policy will terminate when any one of the following events occurs:

1. the owner surrenders the policy;
2. the insured dies;
3. the policy matures; or
4. the required payments are not paid by the end of the grace period.

Annual Report

At least once each year, we will send to the owner a report, which shows the current account value, cash surrender value, outstanding policy loan and death benefit. Also, any premiums paid and charges made since the last report will be provided. The annual report will also include other information as required by state law, regulation or authority.

This report will be mailed within 30 days of the policy anniversary and within 13 months of the last report.

Projection of Values

We will provide a projection of illustrative future death benefits and account values upon written request. The first projection in any policy year will be provided without a service fee. Extra projections will be provided upon request and payment of a \$25 service fee.

The illustration will be based on assumptions as to specified amount(s), benefit option(s) and future premium payments as may be specified by us and/or the owner.

Suicide

For the first two full years from the date of issue, we will not pay the policy proceeds if you commit suicide, while sane or insane. We will terminate the policy and give back the premiums paid less any policy indebtedness and any partial surrender amount.

For the first two full years from the effective date of any increase in benefits, we will not pay the death benefit applicable to the increase if you commit suicide, while sane or insane. We will give back the monthly deductions for the increase in specified amount as a death benefit from the effective date of such increase.

INSURANCE COVERAGE PROVISIONS**Death Benefit**

The death benefit is the greater of the specified amount, or the account value multiplied by the applicable percentage as shown in the Table of Guaranteed Minimum Death Benefit Factors.

Increase in Specified Amount

At any time after the first policy year, the existing insurance coverage may be increased by written request. Any increase in the specified amount requires a written application. Evidence of insurability satisfactory to us must be submitted.

We will amend the policy to show the effective date of the increase. The increase may not be less than \$10,000.

The monthly minimum and monthly lifetime guarantee premiums will be affected following the date of the increase. The new premiums will be based on the attained age at the date of the increase and the total amount of coverage provided by the policy, including any riders and benefits attached, following the increase.

An additional surrender charge may be payable after an increase in specified amount. This charge is described in the surrender charge provision.

Decrease in Specified Amount

The effective date of any decrease will be the monthly anniversary on or next following the date the request is received by us. Any such decrease will first reduce the insurance provided by the most recent increase in specified amount; then, the next most recent increases in specified amount; then the initial specified amount.

The specified amount in effect at any time under this policy may not be less than the minimum specified amount as shown in the policy schedule.

Decreases in specified amount will not affect any applicable surrender charges under this policy. Decreases in specified amount will affect the guideline premiums and monthly guarantee premiums applicable for this policy. We will send you a new policy schedule

which shows the guideline premiums and monthly guarantee premiums in effect after any decreases. Guideline premiums are described in the Premium Limitations provision.

Reduction in Specified Amount Due to Partial Surrender

The specified amount of this policy will be reduced by the amount of the partial surrender including any partial surrender charge payable. The same conditions as described above apply to such decrease in specified amount.

AMOUNT OF PROCEEDS

The life insurance proceeds payable at your death will equal (1) plus (2) plus (3) minus (4) minus (5), where:

- (1) is the death benefit of this policy;
- (2) is any loan interest paid beyond the date of your death;
- (3) is any insurance on your life provided by riders;
- (4) is any policy indebtedness; and
- (5) is the sum of any monthly deductions due and unpaid before the date of your death.

We reserve the right to require the return of the policy at the time of settlement.

BENEFICIARY PROVISIONS**Beneficiary**

Unless otherwise provided by notice to us, the beneficiaries are named in the application.

Change of Beneficiary

During your lifetime, the owner may change the beneficiary designation unless he or she has waived the right to do so, or the beneficiary has been designated as irrevocable. No beneficiary change will take effect until a written notice is received at our administrative office. Such changes will become effective on the date written notice was signed unless otherwise specified by the owner. All changes will be subject to any payment made by us before notice was received.

Death of Beneficiary

Unless otherwise provided in the beneficiary designation:

1. the interest of any beneficiary who dies before you will pass to any surviving beneficiaries according to their respective interests; or
2. if no beneficiary survives you, the proceeds will be paid in one sum to the owner, if living; otherwise, to the owner's estate.

PAYMENT OF PROCEEDS

Any amount payable under this contract will be paid in one sum unless otherwise provided. All or part of this sum may be applied to any payment option. However, options will not be available if:

1. the net proceeds are less than \$2,500;
2. the amount of each payment is less than \$50; or
3. in the case of payment Option 4, the payee is not a natural person receiving payment in his or her own right.

Proceeds left with us may be withdrawn by written notice where such right is given. The payment of any withdrawal may be postponed for as long as six months from the date we receive written notice.

If the proceeds are not paid within 30 days after proof of insured's death has been furnished to the insurer, we will pay interest at the rate of 8% per year.

ELECTION OF PAYMENT OPTIONS

By Owner

During your lifetime, the owner may elect any payment option and may change such election if he or she has reserved the right to do so.

If the owner elects a payment option for the beneficiary, the beneficiary may not:

1. change or cancel the election;
2. assign or transfer the amount held by us; or
3. withdraw any future installments or unpaid interest installments unless these rights are granted in the election.

By Beneficiary

If the owner does not elect a payment option, the beneficiary may do so after your death.

Conditions for Election

Any election or change must be made by written notice to us. No election or change will be effective until we record it.

PAYMENT OPTIONS

The following sections describe the payment options available under this policy.

Option 1 - Proceeds Left at Interest

Under this option, the Company will hold the proceeds. Interest will be paid either once a month, four times a year, twice a year, or once a year. The first payment will be made at the end of the interest frequency period chosen. The guaranteed interest rate is 1.5% a year,

compounded yearly. Proceeds will not be held under this option for more than 30 years.

Option 2 - Payments of a Fixed Amount

Under this option, the Company will make monthly payments in the amount chosen until the proceeds and earned interest have been paid in full. The total amount paid each year must be at least 5% of the original proceeds. The length of the payment period will depend on the amount chosen, the amount of the proceeds applied and the amount of interest earned.

Option 3 - Payments for a Fixed Period

Under this option, the Company will make monthly payments for the number of years chosen. Table A shows the monthly payment for each \$1,000 of proceeds for payment periods of 1 to 30 years. The first installment will be paid on the date proceeds are settled under this option.

Option 4 - Life Income

Under this option, the Company will make monthly payments for the life of the Payee. If a guaranteed payment period is elected, the Company will make payments for at least the period elected, whether or not the named Payee is living.

When this option is elected, the amount of each installment will be based on the Payee's age and sex at the birthday nearest the date the option goes into effect. We have the right to require satisfactory proof of the Payee's age. Table B shows monthly amounts payable at various ages for life with no guarantee, and for 5-year and 10-year guaranteed periods.

Option 4 is available only if the Payee is a natural person who is the Insured, Owner or Beneficiary. This option is not available to a Payee who is an assignee, estate, fiduciary, partnership, or corporation.

Evidence to Survival

We have the right to require satisfactory proof of any payee's age. The right to change options is not available after payments commence under Option 4.

Automatic Payment Option

If settlement of the proceeds of this policy is delayed over 30 days, Option 1 will be applied automatically. Interest will be paid yearly and the person(s) entitled to the proceeds has the right to withdraw the proceeds or elect any payment option permitted by this policy.

Basis of Values

The payment option tables are based on 1.5% interest compounded yearly. For Option 4, rates in the tables are based on the 2000A Mortality Table. We may offer more favorable rates than those determined on this basis.

Additional Options

Any proceeds payable under this policy may be paid under any other method of payment agreed to by us at the time of settlement.

Death of Payee Under Payment Obligations

Unless the Owner or the Beneficiary has made other provisions in electing a payment option, amounts remaining at the Payee's death will be paid to the Payee's estate.

Under Option 1, the proceeds on deposit will be paid in a single sum.

Under Option 2, any unpaid proceeds and earned interest will be paid in a single sum.

Under Option 3 and 4, the present value of any unpaid guaranteed payments will be paid in a single sum. The sum to be paid will equal the total of guaranteed payments remaining, discounted at 1.5% yearly compound interest.

TABLES FOR PAYMENT OPTIONS

Table A, Option 3 - Monthly Payments for Each \$1,000 of Proceeds

Number of Years	Monthly Payments
5	17.28
6	14.51
7	12.53
8	11.04
9	9.89
10	8.96
11	8.21
12	7.58
13	7.05
14	6.59
15	6.20
16	5.85
17	5.55
18	5.27
19	5.03
20	4.81
21	4.62
22	4.44
23	4.28
24	4.13
25	3.99
26	3.86
27	3.75
28	3.64
29	3.54
30	3.44

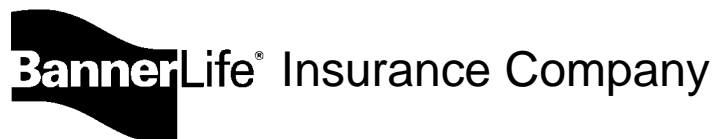
Table B, Option 4 - Monthly Payments for Each \$1,000 of Proceeds

Age	LIFE ONLY		LIFE WITH PERIOD CERTAIN			
	Male	Female	5 Years		10 Years	
			Male	Female	Male	Female
50	3.25	3.00	3.24	3.00	3.22	2.99
51	3.32	3.06	3.31	3.06	3.29	3.05
52	3.39	3.13	3.38	3.12	3.36	3.11
53	3.47	3.19	3.46	3.19	3.44	3.18
54	3.55	3.26	3.54	3.26	3.51	3.25
55	3.64	3.34	3.63	3.33	3.60	3.32
56	3.73	3.42	3.72	3.41	3.68	3.39
57	3.82	3.50	3.81	3.49	3.77	3.47
58	3.93	3.59	3.91	3.58	3.87	3.56
59	4.03	3.68	4.02	3.67	3.97	3.64
60	4.15	3.78	4.13	3.77	4.08	3.74
61	4.27	3.88	4.25	3.87	4.19	3.84
62	4.40	3.99	4.38	3.98	4.30	3.94
63	4.54	4.11	4.52	4.10	4.43	4.05
64	4.69	4.23	4.66	4.22	4.56	4.16
65	4.85	4.37	4.82	4.35	4.69	4.29
66	5.02	4.51	4.98	4.49	4.83	4.41
67	5.20	4.66	5.15	4.64	4.98	4.55
68	5.40	4.83	5.34	4.80	5.13	4.69
69	5.60	5.00	5.53	4.97	5.29	4.84
70	5.82	5.19	5.73	5.15	5.45	5.00
71	6.06	5.40	5.95	5.35	5.62	5.17
72	6.30	5.62	6.18	5.56	5.79	5.34
73	6.57	5.86	6.42	5.78	5.97	5.53
74	6.85	6.11	6.67	6.02	6.15	5.72
75	7.16	6.39	6.94	6.28	6.33	5.91
76	7.48	6.69	7.22	6.56	6.51	6.11
77	7.83	7.02	7.52	6.85	6.69	6.32
78	8.20	7.37	7.83	7.16	6.87	6.52
79	8.60	7.75	8.16	7.49	7.05	6.73
80	9.02	8.17	8.50	7.85	7.23	6.94
81	9.48	8.61	8.85	8.22	7.40	7.14
82	9.97	9.10	9.22	8.61	7.56	7.34
83	10.49	9.63	9.60	9.02	7.72	7.52
84	11.04	10.20	9.98	9.45	7.87	7.70
85	11.63	10.81	10.38	9.88	8.00	7.86
86	12.26	11.47	10.78	10.33	8.13	8.01
87	12.93	12.18	11.18	10.78	8.25	8.15
88	13.65	12.94	11.59	11.23	8.36	8.27
89	14.41	13.75	11.99	11.68	8.45	8.38
90	15.21	14.59	12.39	12.11	8.54	8.48
91	16.07	15.48	12.78	12.53	8.62	8.57
92	16.97	16.40	13.17	12.94	8.69	8.64
93	17.93	17.36	13.56	13.33	8.75	8.71
94	18.96	18.37	13.93	13.71	8.80	8.77
95	20.07	19.42	14.30	14.07	8.84	8.82

Income Payments for ages not shown furnished upon request.
The values above are based on 1.5% and the 2000A Mortality Table.

TABLE OF GUARANTEED MINIMUM DEATH BENEFIT FACTORS

Attained Age	Percentage	Attained Age	Percentage	Attained Age	Percentage
0-40	250%	54	157%	68	117%
41	243%	55	150%	69	116%
42	236%	56	146%	70	115%
43	229%	57	142%	71	113%
44	222%	58	138%	72	111%
45	215%	59	134%	73	109%
46	209%	60	130%	74	107%
47	203%	61	128%	75-90	105%
48	197%	62	126%	91	104%
49	191%	63	124%	92	103%
50	185%	64	122%	93	102%
51	178%	65	120%	94	101%
52	171%	66	119%	95	101%
53	164%	67	118%	& over	



1701 Research Boulevard
Rockville, MD 20850
800-638-8428

Flexible Premium Adjustable Life Insurance

Adjustable death benefit is payable upon your death prior to the maturity date

Flexible premiums are payable during your lifetime until the maturity date

Cash surrender value, if any, payable at maturity

Plan, benefits, classification and period for which premiums are payable as stated in the policy schedule

This policy is non-participating and no dividends are payable

Policy Schedule (Continued)

Policy Number: 010000000

Table of Full Surrender Charges

POLICY YEAR	SURRENDER CHARGE
1	\$ 1870.00
2	\$ 1736.00
3	\$ 1603.00
4	\$ 1469.00
5	\$ 1336.00
6	\$ 1202.00
7	\$ 1069.00
8	\$ 935.00
9	\$ 801.00
10	\$ 668.00
11	\$ 534.00
12	\$ 401.00
13	\$ 267.00
14	\$ 134.00
15	\$ 0.00
	AND THEREAFTER

Policy Schedule (Continued)

Policy Number:

 GUARANTEED MAXIMUM MONTHLY COST OF INSURANCE RATES PER \$1,000
 RATING CLASSIFICATION: MALE STANDARD NON-TOBACCO

POLICY YEAR	ATTAINED AGE	MAXIMUM RATE	POLICY YEAR	ATTAINED AGE	MAXIMUM RATE
1	35	0.090833	44	78	4.537500
2	36	0.095833	45	79	5.072500
3	37	0.100000	46	80	5.655833
4	38	0.107500	47	81	6.320000
5	39	0.114167	48	82	7.011667
6	40	0.121667	49	83	7.757500
7	41	0.131667	50	84	8.583333
8	42	0.144167	51	85	9.505833
9	43	0.158333	52	86	10.528333
10	44	0.175000	53	87	11.645000
11	45	0.194167	54	88	12.841667
12	46	0.212500	55	89	14.104167
13	47	0.232500	56	90	15.421667
14	48	0.244167	57	91	16.660833
15	49	0.257500	58	92	17.952500
16	50	0.276667	59	93	19.315000
17	51	0.299167	60	94	20.754167
18	52	0.330000	61	95	22.265833
19	53	0.363333	62	96	23.649167
20	54	0.405833	63	97	25.124167
21	55	0.458333	64	98	26.698333
22	56	0.511667	65	99	28.378333
23	57	0.569167	66	100	30.175000
24	58	0.618333	67	101	31.600833
25	59	0.675000	68	102	33.120000
26	60	0.743333	69	103	34.736667
27	61	0.826667	70	104	36.456667
28	62	0.928333	71	105	38.260833
29	63	1.042500	72	106	40.179167
30	64	1.162500	73	107	42.218333
31	65	1.289167	74	108	44.385833
32	66	1.417500	75	109	46.688333
33	67	1.547500	76	110	49.132500
34	68	1.687500	77	111	51.728333
35	69	1.832500	78	112	54.483333
36	70	2.008333	79	113	57.409167
37	71	2.205000	80	114	60.512500
38	72	2.463333	81	115	63.805833
39	73	2.735833	82	116	67.299167
40	74	3.022500	83	117	71.004167
41	75	3.335833	84	118	74.935000
42	76	3.677500	85	119	79.101667
43	77	4.074167			